NYU **Hospital for Joint Diseases**

NYU LANGONE MEDICAL CENTER

Workers Compensation / No Fault Insurance Registration Form

◯ Workers Compensation ◯ No Fault (PLEASE CHECK ONE)

PATIENT NAME: _____

NAME OF INSURANCE/COVERAGE: _____

CLAIM ADDRESS FOR INSURANCE/COVERAGE: _____

_____

_____

WCB CASE # _____ OR CLAIM # _____

CARRIER CASE # _____ OR POLICY # _____

DATE OF INJURY/ACCIDENT: _____ TIME OF INJURY: _____

CLAIM MANAGER/ADJUSTER: _____

PHONE #: _____ EXT. _____ FAX #: _____

BODY PART: _____ CURRENTLY WORKING? _____

IF YES, FULL TIME OR PART TIME? _____ IF NO, WHEN DID YOU STOP? _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____

_____

_____

EMPLOYER PHONE NUMBER: EXT. FAX #

PLEASE EXPLAIN HOW INJURY OCCURRED: _____

_____

_____

_____

SIGNATURE: _____ DATE: _____

Department of Orthopaedic Surgery
NYU Hospital for Joint Diseases: 301 East 17th Street, New York, NY 10003 • tel: 212.598.6498 • fax: 212.598.6581
NYU Langone Medical Center: 550 First Avenue, New York, NY 10016 • tel: 212.263.6391 • fax: 212.263.8217

Name:

DOB: Age:

Date:

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS ON AND AFTER 3/1/02)

Claim Number: _____

I,_____ ("Assignor") hereby assign to **Dr Mehul R.Shah** all rights privileges and remedies to payment for healthcare services provided by assignee to which I am entitled under article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident, which occurred on _____, not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT DESTRUCTION DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ (Print Name of Patient)

_____ (Signature of Patient)

_____ (Address of patient)

_____ (Date of Signature)

NY Hospital for Joint Diseases
(Print Name of Provider)

_____ (Signature of Provider)

761 Merrick Avenue

Westbury, NY 11590
(Address of Provider)

_____ (Date of Signature)

NYS FORM NF-A0B (Rev 1/2004)